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Focus on Behavioral Health

Long-stigmatized, behavioral health conditions are finally becoming a focal point not just for policy makers but also in public discussions about the well-being of the United States. This is in part due to a rising opioid epidemic, the concentration of people with mental illnesses in prisons and jails, and a greater appreciation of the toll taken by depression and other mental disorders on individuals, families, and the economy. The United States spends more on mental health and addiction than on any other medical condition, including heart disease, trauma, and cancer. Within this spending, there’s been a shift toward outpatient and other types of community treatment and away from inpatient care. Meanwhile, the Affordable Care Act has made it possible for more people with serious mental illnesses to obtain care, but treatment rates for racial and ethnic minorities still trail those of whites.

Mental health and criminal justice

The rates of incarceration for mental illness have tended to decline over time. The most frequently reported justification for mental health-related incarcerations is, including parole, remand, and mental health treatment issues.

Guns and mental health in Florida

The percentage of individuals who have a history of mental illness who also have a history of firearm purchase or possession has been found to be much lower than for the overall population.
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Panel 1:

Insurance Coverage and Parity

Health Affairs
Risk Adjustment Simulation: Plans May Have Incentive To Distort Mental Health And Substance Use Coverage

Ellen Montz, Tim Layton, Alisa Busch, Randall Ellis, Sherri Rose, and Thomas McGuire
**EXHIBIT 2**

Total average spending and total average mental health and substance use spending per person in the sample, 2013

**Source** Authors' analysis of sample data. **Notes** Recognized and unrecognized categories (described in the text) are mutually exclusive. People without mental health and substance use disorder diagnoses have mental health spending because some mental health and substance use treatments, particularly prescription drugs, have applications other than treating mental health and substance use disorders.
EXHIBIT 3

Clinical Classification Software (CCS) categories for individuals with mental health and substance use diagnoses who are unrecognized by the Marketplace model

<table>
<thead>
<tr>
<th>Category</th>
<th>Unrecognized individuals</th>
<th>Percent of MHSUD spending for unrecognized individuals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adjustment disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attention deficit/conduct/disruptive behavior disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delirium/dementia/amnestic/other cognitive disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mood disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol-related disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance-related disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Screening and history of MHSUD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Miscellaneous mental disorders</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SOURCE Authors’ analysis of sample data. NOTES Percentages of unrecognized individuals (described in the text) and total mental health and substance use disorder (MHSUD) spending are not additive, since individuals can have diagnoses associated with more than one CCS category. For example, a person with a diagnosis code for screening and history of mental health and substance use disorders is also likely represented in another category, such as anxiety disorders. The exhibit does not include CCS categories with less than 1 percent of individuals or less than 1 percent of total spending: developmental disorders, disorders usually diagnosed in infancy/childhood/adolescence, impulse control disorders, personality disorders, schizophrenia and other psychotic disorders, and suicide and intentional self-inflicted injury.
# Exhibit 4

## Predictive Ratios for Individuals with Mental Health and Substance Use Diagnoses Who Are Recognized and Unrecognized by the Marketplace Model

<table>
<thead>
<tr>
<th>Category</th>
<th>Full Sample</th>
<th>Recognized Individuals</th>
<th>Unrecognized Individuals</th>
</tr>
</thead>
<tbody>
<tr>
<td>All individuals with MHSUD diagnoses</td>
<td>0.84</td>
<td>0.97</td>
<td>0.79</td>
</tr>
<tr>
<td>Recognized individuals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unrecognized individuals</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Unrecognized Individuals with MHSUD Diagnoses

<table>
<thead>
<tr>
<th>Subcategory</th>
<th>Predictive Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adjustment disorders</td>
<td>0.69</td>
</tr>
<tr>
<td>Anxiety disorders</td>
<td>0.76</td>
</tr>
<tr>
<td>Delirium/dementia/amnestic/other cognitive disorders</td>
<td>0.87</td>
</tr>
<tr>
<td>Mood disorders</td>
<td>0.78</td>
</tr>
<tr>
<td>Alcohol-related disorders</td>
<td>0.87</td>
</tr>
<tr>
<td>Substance-related disorders</td>
<td>0.78</td>
</tr>
<tr>
<td>Screening and history of MHSUD</td>
<td>0.83</td>
</tr>
<tr>
<td>Miscellaneous mental disorders</td>
<td>0.71</td>
</tr>
</tbody>
</table>

**Source**: Authors’ analysis of sample data. **Notes**: Diagnoses are based on Clinical Classification Software (CCS) categories, as in Exhibit 3. Recognized and unrecognized individuals (described in the text) are mutually exclusive. Predictive ratios measure how well the risk-adjustment system compensates health insurance plans for a subgroup by taking the ratio of average plan liabilities (total plan payments minus [compensated] predicted payments based on the Health and Human Services—Hierarchical Condition Category [HHS-HCC] model) to average actual total payments for each subgroup of individuals. The exhibit does not include CCS categories with less than 1 percent of individuals or less than 1 percent of total spending; developmental disorders, disorders usually diagnosed in infancy/childhood/adolescence, impulse control disorders, personality disorders, schizophrenia and other psychotic disorders, and suicide and intentional self-inflicted injury.
Comparison Of The Identification Of Individuals With Mental Health And Substance Use Disorders Between The HHS Risk-adjustment Models:

- Marketplace model – 20 percent
- Medicare Advantage model – 20 percent
- Medicare Part D model – 54 percent
  - The majority of those uniquely captured had mood or anxiety disorders
- Medicare Advantage and Part D combined – 56 percent

Conclusions
- This study documents how the Marketplace risk-adjustment system generates incentives for plans to engage in service-level selection
- This study suggests one potential step that could be taken to ameliorate this problem: the incorporation of diagnoses used in Medicare Part D risk adjustment.
Access to mental health services is one of the most important and most neglected civil rights issues facing the Nation.

Rep. Patrick Kennedy (D-RI)

Parity applied to:

• Quantitative treatment limits (e.g., cost sharing, deductibles, day/visit limits for in and out-of-network services)

• Non-quantitative treatment limits (e.g., network adequacy standards, utilization review, prior authorization)
Evidence On Effects Of Federal Parity Law

- Extensive evidence-base on the effects of parity prior to passage of Domenici-Wellstone law
- Published research on effects of Domenici-Wellstone law and parity under the ACA very limited to date
- Substantial benefit changes by plans and very few employers dropped coverage; yet, compliance problems identified
- Published insurance claims studies just beginning to come out; limited by national scope of policy and by timeframe
Recommendations: Research, Monitoring And Enforcement

- Compliance with treatment limits
- Parity for certain diagnoses and treatment types
- Financial protection objective
- Multi-agency enforcement
DATAWATCH

Access To Mental Health Care Increased But Not For Substance Use, While Disparities Remain

Timothy B. Creedon, MA
The Heller School for Social Policy and Management
Brandeis University

Benjamin Lê Cook, PhD
Health Equity Research Lab
Cambridge Health Alliance/Harvard Medical School
The ACA And Access To Mental Health And Substance Use Care

- ACA health insurance reforms in 2014
  - Medicaid expansion
  - State-based insurance marketplaces
  - Extension of the 2008 parity law (MHPAEA)

- What changed for people with mental health and substance use treatment needs?
  - More insurance coverage?
  - Increased access to care?
  - What about racial/ethnic disparities?
Mental Health Treatment Rates Increased In 2014 among individuals with past-year serious psychological distress (SPD)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>51.3</td>
<td>52.3</td>
<td>51.9</td>
<td>55.3</td>
</tr>
<tr>
<td>Hispanic</td>
<td>29.1</td>
<td>31.3</td>
<td>31.8</td>
<td>35.6</td>
</tr>
<tr>
<td>Black</td>
<td>31.0</td>
<td>31.6</td>
<td>32.2</td>
<td>35.9</td>
</tr>
<tr>
<td>Asian</td>
<td>25.0</td>
<td>29.8</td>
<td>29.8</td>
<td>33.6</td>
</tr>
<tr>
<td>All</td>
<td>44.8</td>
<td>46.6</td>
<td>45.8</td>
<td>48.8</td>
</tr>
</tbody>
</table>

2014 significantly different from: a2005-07; b2008-10; c2011-13 (p<.05)

SOURCE: Authors’ analysis of 2005-2014 NSDUH data
Substance Use Treatment Rates Were Flat In 2014
among individuals with past-year substance use disorders (SUD)

SOURCE: Authors’ analysis of 2005-2014 NSDUH data

*2005-07 results for Asians omitted due to small cell size
Health Insurance Coverage Rates Increased In 2014 among individuals with past-year SPD or SUD or both

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>78.7</td>
<td>78.6</td>
<td>79.4</td>
<td>a,b,c</td>
</tr>
<tr>
<td>Hispanic</td>
<td>63.4</td>
<td>65.8</td>
<td>66.5</td>
<td>a,b,c</td>
</tr>
<tr>
<td>Black</td>
<td>76.2</td>
<td>74.4</td>
<td>71.2</td>
<td>c</td>
</tr>
<tr>
<td>Asian</td>
<td>81.8</td>
<td>85.2</td>
<td>82.6</td>
<td></td>
</tr>
<tr>
<td>All</td>
<td>76.1</td>
<td>76.3</td>
<td>76.5</td>
<td>a,b,c</td>
</tr>
</tbody>
</table>

2014 significantly different from: a2005-07; b2008-10; c2011-13 (p<.05)

SOURCE: Authors’ analysis of 2005-2014 NSDUH data
Cost And Insurance Problems Were Commonly Cited Reasons For Unmet MH Treatment Need In 2014 among individuals with past-year SPD

- White: 53.3%
- Hispanic: 46.5% *
- Black: 43.1% *
- Asian: 47.7%
- All: 51.1%

*Significantly different from non-Hispanic Whites (p<.05)

SOURCE: Authors’ analysis of 2005-2014 NSDUH data
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Panel 2:
Meeting Behavioral Health Care Needs
Building The Mental Health Workforce Capacity Needed To Treat Adults With Serious Mental Illness

Mark Olfson, MD, MPH
Columbia University
New York, NY
Many Adults With Serious Mental Illnesses Do Not Receive Treatment

No Mental Health Treatment

Serious mental illness (7%): 40.9%

Of the approximately 6.9 million adults with serious mental illnesses in the US, approximately 2.8 million do not receive any mental health treatment.

Unmet need for treatment is concentrated among adults in rural areas, with low incomes, and without health insurance.

After Walker ER et al, *Psych Serv* 2015 (2011 NSDUH); Roll JM et al., *Psych Serv* 2013 (NHIS)
Shortages Of Mental Health Professionals

Konrad TR et al., Psych Serv 2009, (NCS-R, MEPS, Professional Associations)
Counties light to dark indicate first to fourth quartiles in mental health professional shortages
Trends In Acceptance Of Medicaid And Private Insurance – Psychiatrists And Other Mds

Bishop TF et al *JAMA Psychiatry* 2014 (NAMCS) (Blue lines represent psychiatrists; red lines all other medical specialties)
Some Policy Strategies To Build Mental Health Workforce Capacity

- Expanding federal and state loan repayment programs to work in underserved areas (NHSC)
- Increasing Medicaid reimbursement for treating patients with serious mental illnesses
- Training social workers in evidence-based psychosocial treatments
- Building team-based mental health services in primary care
State Prescription Drug Monitoring Programs Are Prominent Tools To Combat The Opioid Epidemic

All 50 states except Missouri now have such programs

24 states implemented or upgraded programs during 2001-2010

This study examines effects of implementation on prescribing of opioids and other pain medication
Launch of Drug Monitoring Programs associated with a 30% reduction in Schedule II opioid prescribing

Schedule II opioids are the category of opioids with the highest potential for abuse and dependency
ME: Marginal effect
Effects On Schedule II Opioid Prescribing Was Sustained Over Time

Marginal Effect

0-6 7-12 13-18 19-24 25 or more

Months since implementation of drug monitoring program
Conclusions And Policy Implications

• Launch of a drug monitoring program was associated with a 30% reduction in the likelihood of prescribing a Schedule II opioid

• The effect was sustained over time

• Drug monitoring programs likely raised awareness of prescribers about opioid misuse

• Future research will examine effectiveness of additional policies governing the use of drug monitoring programs
Acknowledgement

• Funding
  – CHERISH Center pilot award (P30DA040500)
  – TRIPLL pilot award (P30AG022845)
  – NIMH career development award (K01MH090087)

• Ashley Eggman, MS provided excellent assistance with the manuscript

• Cary Reid, MD, PhD provided helpful input
Supported Employment Boosts Employment for People with Serious Mental Illnesses, But Funding Is Lacking

Robert E. Drake  
Gary R. Bond  
Howard H. Goldman  
Michael F. Hogan  
Mustafa Karakas  

HealthAffairs
The Problem

• New SSDI and SSI awards to people with mental illness have been rising for years
• Most of these people want to work
• Support Employment Services help 65% to achieve competitive employment, but they do not leave social security rolls

(Danzinger et al., 2009)
Evidence-Based Supported Employment

- Team-based, patient-centered, rapid job search, job development, follow-along supports
- Example
The Dilemma

• No clear funding mechanism
• Programs must blend funds from Medicaid, Vocational Rehabilitation, state and local mental health contracts, Ticket to Work, and charity
• A simple funding stream would rapidly increase employment of those on disability
• May prevent others from entering disability status
Insurance Financing Increased For Mental Health Care But Not For Substance Use Disorders, 1986-2014

Tami Mark, PhD, MBA
Truven Health Analytics, an IBM Company
June 7, 2016

Co-authors: Tracy Yee, Katharine R. Levit, Jessica Camacho-Cook, Eli Cutler, and Christopher D. Carroll
Background

• Truven Health has contracted with the Substance Abuse and Mental Health Services Administration (SAMHSA) to track spending on mental health and substance use disorder services for the past 2 decades.

• Behavioral health treatment expenditures from 1986 through 2014.

• Addition of information on use of mental health and substance use disorder services
Combined spending by private insurance, Medicaid, and Medicare as a share of all spending for mental health and substance use disorder treatment.
Percentage of civilian noninstitutionalized people ages 18 and older receiving mental health treatment, by setting.
Percentage of civilian noninstitutionalized people ages 18 and older receiving substance use disorder treatment and prescription fills for substance use disorders.
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Panel 3:
Interaction With The Criminal Justice System
Improving Access To Care And Reducing Involvement In The Criminal Justice System For People With Mental Illness

Alene Kennedy-Hendricks, PhD
Johns Hopkins Bloomberg School of Public Health

Collaborators: Colleen L. Barry, Haiden Huskamp, and Lainie Rutkow

Health Affairs
Criminal justice involvement among noninstitutionalized adults with and without serious mental illness

With SMI: Lifetime history of arrest
Without SMI: Lifetime history of arrest

SOURCE Authors’ analysis of data for 2008–14 from the National Survey of Drug Use and Health.
Causal Explanations And Implications For Solutions

• Evolution in thinking about the causes of disproportionate involvement of people with mental illness in criminal justice system
  – Criminalization of mental illness
  – Role of criminogenic risk factors
• Implications for potential solutions
• Opportunities presented by national health reforms
## Sequential Intercept Model developed by Patricia Griffin, Mark Munetz and Hank Steadman

<table>
<thead>
<tr>
<th>Intercept Point</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Law enforcement and emergency services</td>
<td>Specialized crisis response teams, stabilization centers</td>
</tr>
<tr>
<td>2. Initial detention and initial court hearings</td>
<td>Screening and pre-trial diversion</td>
</tr>
<tr>
<td>3. Courts, jails, and prisons</td>
<td>Mental health and drug courts, peer support programs</td>
</tr>
<tr>
<td>4. Reentry from jails and prisons</td>
<td>Medicaid eligibility assessment and enrollment</td>
</tr>
<tr>
<td>5. Community corrections and community support</td>
<td>Specialty mental health caseloads, forensic assertive community treatment</td>
</tr>
</tbody>
</table>
Substance Use Disorder Treatment Among Criminal Justice-Involved Adults: Trends From 2004 To 2014

Brendan Saloner, PhD
Johns Hopkins Bloomberg School of Public Health
Health Affairs behavioral health briefing
June 7, 2016
In Recent Years, One-third Of US Justice-involved Adults Had Substance Use Disorders
The Uninsured Rate Among Justice-involved Adults With Suds Declined Rapidly In 2014

***P<.01 pairwise t-test versus 2009-2013 mean
No Significant Increase In SUD Treatment Use In 2014, But Medicaid Paid For More Care

- Payment source for treatment among those who used treatment
  (>1 payment source can be reported)

**P<.05 pairwise t-test versus 2009-2013 mean**
Policy Implications

• ACA Medicaid expansion creates new opportunities to screen and engage the justice-involved in SUD treatment

• Yet more than one-quarter of justice-involved remain uninsured indicating much room for improvement

• Beyond coverage, the justice system can improve corrections treatment and link to community resources

• Improving access to SUD care for the justice-involved requires upfront resource investment, but there is a meaningful return on the investment
Gun Violence, Mental Illness, And Laws That Prohibit Gun Possession
Evidence From Two Florida Counties

Jeffrey W. Swanson, Michele M. Easter, Allison G. Robertson, Marvin S. Swartz, Kelly Alanis-Hirsch, Daniel Moseley, Charles Dion, John Petrila

Health Affairs
Research Questions

• How prevalent is gun violence (firearm-related crime and suicide) among people with serious mental illnesses who are served in the public behavioral health system?

• What proportion of these individuals are legally eligible vs. prohibited from buying guns, and why?

• How effective are the legal gun restrictions and point-of-purchase background checks in preventing gun crime and suicide in the people with serious mental illnesses?
Features Of The Study

• 10-year longitudinal study (2002 – 2011)
• 81,704 people with serious mental illnesses
• Schizophrenia, bipolar disorder, depression
• Public behavioral health system clients
• Miami-Dade and Pinellas Counties, Florida
• Matched mental health, public safety, civil court, criminal justice, and death records
50 Gun Suicides: Gun Prohibited Status At Death

Prohibited: 28%

Not prohibited: 72%
Arrest Rate Before And After NICS Reporting

Before NICS reporting  |  After NICS reporting
---|---
County adult population  |  915.2  |  892.9
No involuntary intervention  |  883.7  |  683.0
Involuntary short-term hold  |  1,041.9  |  943.3
Mental health adjudication  |  1,828.1  |  997.4

Not gun prohibited
Gun prohibited
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Panel 4: Equity
Removing Obstacles To Eliminating Racial And Ethnic Disparities In Behavioral Health Care

Margarita Alegria, PhD, Kiara Alvarez, PhD, Rachel Ishikawa, PhD, Karissa DiMarzio, and Samantha McPeck

HealthAffairs
Health reform promotes the expansion of behavioral healthcare and improved access to care, but many initiatives fail to consider who the patient is, and that disparities reduction initiatives must reflect changing U.S. demographics.

• Many are low-income and previously uninsured ethnic/racial minorities with:
  – Limited English proficiency
  – Previous experiences of poor access
  – Low-quality or coerced care
  – Low expectations about the value of healthcare
We Illustrate How Mistaken Assumptions Guiding Health Reform Risk Replicating Treatment Disparities.

- We propose modifications to usual practice, including
- 1) tailoring the provision of care to reflect actual patterns of service utilization and access;
- 2) promoting services to respond to patient needs and preferences, and restructuring reimbursement practices to accommodate new innovations; and
- 3) allowing flexibility in evidence-based practice and expansion of behavioral health workforce to meet the needs of a growing racial/ethnic minority population.
Our Studies And Others Show…

• Intensive outreach at odds with standard clinical practices such as removing patients after several missed appointments. Need for persistent rescheduling for minority patients to receive adequate dose of Tx.

• A system that requires face-to-face engagement while disregarding personal costs of transportation, time demands (i.e. irregularity in work schedules, inability to take time off), and lack of linguistic and cultural competence that minorities confront.

• Billing restrictions hamper policy efforts to expand innovative delivery of behavioral healthcare.

• A high bar for “medical necessity,” demanding documentation, and limitations on billing for care coordination.

• Most EBPs are only available in English and few have been adapted for ethnic/racial populations, much less tested w/ them.

• Lack of diversity within the behavioral health workforce
**Summary**

**Mistaken Assumptions**

1) Improvement in health care access alone will reduce disparities.

2) Current service planning addresses minority patients’ preferences.

3) Evidence-based interventions are readily available for diverse populations.

**Recommendations**

1) Expand outreach beyond clinic walls, with a focus on engaging racial/ethnic minority groups.

2) Collect data on patients’ preferences.

3) Adapt EBPs to the target communities through partnerships among researchers, clinicians, and community leaders.
Decline In Public Substance Use Disorder Treatment Centers Most Serious In Counties With High Shares Of Black Residents

Janet R. Cummings, PhD
Hefei Wen, PhD
Michelle Ko, MD, PhD

HealthAffairs
Study Overview

Objectives

- Describe trends in supply of substance use disorder treatment facilities
- Examine implications for counties with high shares of black residents

Data: National Survey of Substance Abuse Treatment Services 2002 – 2010

Outcome: County has any outpatient facility (yes/no)

Variable of Interest: County % of Black residents

- Below Mean (<10%)  (N=2,265)
- 10 - 25%  (N=413)
- 25 - 41%  (N=243)
- At least 41%  (N=218)

Methods: Regression models adjust for other county characteristics
Trends In The Supply Of Substance Use Disorder Treatment Facilities

Private, nonprofit: ↓ 9.8%

Private, for profit: ↑ 19.1%

Public facilities: ↓ 17.2%
Geographic Availability Of Any Outpatient Facility By County Share Of Black Residents, 2002

Any Facility

Public

Private, Nonprofit

Private, For profit

<10% Black

10 - 25% Black

25 - 41% Black

>41% Black

* p<0.05

** p<0.01

*** p<0.001
Geographic Availability Of Any Outpatient Facility By County Share Of Black Residents, 2010

Any Facility
- <10% Black
- 10 - 25% Black
- 25 - 41% Black
- >41% Black

Public
- <10% Black
- 10 - 25% Black
- 25 - 41% Black
- >41% Black

Private, Nonprofit
- <10% Black
- 10 - 25% Black
- 25 - 41% Black
- >41% Black

Private, For profit
- <10% Black
- 10 - 25% Black
- 25 - 41% Black
- >41% Black

* p<0.05  
** p<0.01  
*** p<0.001
Rapid Growth Of Antipsychotic Prescriptions For Children Who Are Publically-Insured Has Ceased, But Concerns Remain

Stephen Crystal, PhD
Rutgers University
Background/Aims

- Sharp increase in antipsychotic medication use among Medicaid children in 2000s.
- Use especially high in foster care youth.
- State and federal initiatives in response.
- Need to define best practices and measure extent to which treatment is consistent with them.
- We examined changes in prescribing patterns following policy changes using administrative data, and examined quality measures in states.
- Study population: ages 0-17, foster care vs other Medicaid-eligible children.
Trends In Antipsychotic Use

EXHIBIT 1

Antipsychotic medication use among children ages 0–17, by insurance and foster care status

SOURCE Authors' analysis of Thompson MarketScan data (privately insured) and Medicaid Analytic Extract data.
### Antipsychotic Use Among Medicaid Children By Foster Care Status: Diagnoses In 2010

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>% receiving antipsychotic meds in 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Foster care</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>77.89</td>
</tr>
<tr>
<td>Autism/mental retardation</td>
<td>31.12</td>
</tr>
<tr>
<td>Bipolar disorder</td>
<td>76.98</td>
</tr>
<tr>
<td>Conduct disorder, no ADHD</td>
<td>19.24</td>
</tr>
<tr>
<td>Conduct disorder, with ADHD</td>
<td>38.46</td>
</tr>
<tr>
<td>ADHD</td>
<td>19.93</td>
</tr>
<tr>
<td>Anxiety or depression</td>
<td>13.84</td>
</tr>
<tr>
<td>Adjustment-related disorders</td>
<td>2.66</td>
</tr>
<tr>
<td>Other mental health disorders</td>
<td>6.42</td>
</tr>
<tr>
<td>None of the above</td>
<td>1.39</td>
</tr>
</tbody>
</table>
# Quality Measures In Three States By Foster Care Status In 2009 And 2011

<table>
<thead>
<tr>
<th>Measure</th>
<th>Population</th>
<th>% in 2009</th>
<th>% in 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Polypharmacy (2+ antipsychotics)</td>
<td>All</td>
<td>3.76%</td>
<td>3.02%</td>
</tr>
<tr>
<td></td>
<td>Foster Care</td>
<td>3.98%</td>
<td>2.76%*</td>
</tr>
<tr>
<td></td>
<td>Non-Foster Care</td>
<td>3.70%</td>
<td>3.08%</td>
</tr>
<tr>
<td>Psychosocial care (-90/+30 days)</td>
<td>All</td>
<td>31.92%</td>
<td>32.78%</td>
</tr>
<tr>
<td></td>
<td>Foster Care</td>
<td>58.22%</td>
<td>65.47%*</td>
</tr>
<tr>
<td></td>
<td>Non-Foster Care</td>
<td>28.08%</td>
<td>29.01%</td>
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<tr>
<td>Metabolic monitoring (any blood glucose and cholesterol test)</td>
<td>All</td>
<td>20.39%</td>
<td>19.55%</td>
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<tr>
<td></td>
<td>Foster Care</td>
<td>25.08%</td>
<td>28.09%*</td>
</tr>
<tr>
<td></td>
<td>Non-Foster Care</td>
<td>19.32%</td>
<td>18.01%</td>
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* chi-squared for 2009 vs 2011 significant (p<0.001)
Conclusions

• Upward trend has ceased, but “new normal” rates of current prescribing remains a concern.
• 3% of Medicaid-insured children in foster care account for 15% of all Medicaid-insured children treated with antipsychotics.
• High rates of treatment in this group, alongside gaps in best practices (concurrent medications, psychosocial interventions, metabolic monitoring) need to be addressed.
• Specialized managed care plans for foster care children are promising strategy to improve oversight and access to alternative interventions.
• Promulgation of national consensus HEDIS measures for safe and judicious prescribing provides new tools for quality improvement.
For Its Support Of The June 2016 Thematic Issue On Behavioral Health And This Briefing
Roundtable Discussion:
Emerging Issues In Behavioral Health

HealthAffairs
Larry Davidson
Professor of Psychiatry and Director, Yale Program for Recovery and Community Health
Yale University
Suicide Prevention In Health Care: Needed, And Promising

Michael Hogan, PhD

Health Affairs
Despite Health Care Progress, Suicide Deaths Rise
Suicide And Health Care Settings

• 45% of people who died by suicide had contact with primary care providers in the month before death. Among older adults, it’s 78%.

• South Carolina: 10% of people who died by suicide were seen in an emergency department in the prior 60 days.

• Many deaths among people receiving mental health care:
  – Ohio: Between 2007-2011, 20.2% of people who died from suicide received public behavioral health care within 2 years of death.
  – New York: In 2012 there were 226 reported suicide deaths among consumers of public mental health services, accounting for 13% of all suicide deaths in the state.
  – Vermont: In 2013, 20.4% of the people who died from suicide received state-funded BH care in the prior year.
Suicide Care Is Possible: Henry Ford Health System

Launch: Perfect Depression Care

Suicide Deaths/100k HMO Members

- 1999
- 2001
- 2003
- 2005
- 2007
- 2009
- 2011
Implementing Zero Suicide: Progress, Challenges

- 2011-2013: Model built out/implemented in advanced primary care, mental health settings: it’s feasible
- 2013: Website developed by Suicide Prevention Resource Center with all tools available online [www.zerosuicide.com](http://www.zerosuicide.com)
- 2016:
  - The Joint Commission issues Sentinel Event Alert encouraging suicide prevention in all ambulatory, inpatient health settings
  - Implementation underway in 200+ settings, 15 states
- Challenges:
  - Vestigial separation of brain care, body care
  - Very limited resources for suicide prevention
  - Implementation challenges of “slow ideas”
Quality Measures For Mental Health And Substance Use

*Behavioral Health Meets The “Quality Measurement Industrial Complex”*

Harold Alan Pincus, MD
Vice Chair, Department of Psychiatry, Columbia University's College of Physicians and Surgeons, and Director of Quality and Outcomes Research, New York Presbyterian Hospital
Current State Of Behavioral Health Quality Measurement

- 510 measures identified but only 5% actually used in major quality reporting programs
- 10% endorsed by National Quality Forum
- 72% focus on processes quite distal to outcomes (e.g., screening/assessment)
- Little reliance on EHR
- Few measures in key CMS programs such as Medicare Advantage Star Ratings, ACO, etc.
- Impact of quality measures limited
- Level of performance and rate of improvement is poor compared to general medical conditions
- Overall limited progress since 2006 IOM report
Average Performance Rates On HEDIS Quality Measures For Behavioral Health Conditions Versus Diabetes And Hypertension, By Product Line, 2014

<table>
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<td>48</td>
<td>43.7</td>
<td>45.4</td>
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<td>Diabetes/Hypertension Measures</td>
<td>71.6</td>
<td>66.2</td>
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<th>Medicare</th>
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</thead>
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<td>Behavioral Health Measures</td>
<td>-1.9</td>
<td>4.4</td>
<td>-3.0</td>
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<tr>
<td>Diabetes/hypertension Measures</td>
<td>4.9</td>
<td>5.5</td>
<td>6.8</td>
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</table>
“Quality Measurement Industrial Complex”

Process

• Establishing an evidence base
• Translating evidence to guidelines
• Translating guidelines to measure concepts
• Operationalizing concepts to measure specifications (numerator/ denominator)
• Testing for reliability, validity, feasibility
• Endorsement
• Adoption/Use
• Aligning measures across multiple programs
• Stewardship/Updating
Key Priorities For Measure Development

• Expansion of outcomes measures
  – symptoms, functioning, recovery, POR
• Structural approaches
  – TJC, PCMH, CCBHC
• Integrated care
  – access for BH in PC and PC in BH, segmentation/disparity
• Psychosocial interventions
  – structure, process (EBP’s), outcomes
• Substance abuse
  – expanded coverage in ACA, opioid epidemic
Moving From Measurement To Improvement

- Provide investment, leadership, and coordination
- Develop evidence (for guidelines and measures)
- Improve and link data sources
- Build clinical workforce capacity
- Engage consumers and families
Trends In News Media Coverage Of Mental Illness In The United States: 1995-2014

Emma E. McGinty, PhD, MS
Alene Kennedy-Hendricks, PhD
Seema Choksy, MPP
Collen L. Barry, PhD, MPP

Health Affairs
Few Changes In News Media Coverage Of Mental Illness Over Past 2 Decades

• Disproportionate focus on interpersonal violence
• Increased linkage of mental illness with mass shootings
• Little coverage of successful treatment and recovery
• Very low coverage of behavioral health policy
Implications

- The news media’s emphasis on violence and lack of focus on successful treatment, recovery, and mental health system and policy issues has concerning implications for social stigma.
- News media messages linking mental illness and violence are frequently used as arguments for improving the mental health system.
- Mental health treatment is often framed as a violence prevention strategy, despite lack of evidence supporting this relationship.
Health Affairs thanks

California Health Care Foundation

Takeda

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Thank You!

Health Affairs invites you to join us for our next event:

Global Health: Patient Safety, Cancer Care, Universal Health Coverage and Innovation

Tuesday, June 14, 2016
National Press Club